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Surprise Medical Billing Protections Under the Consolidated Appropriations Act, 2021

By Alden Bianchi[*]
Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C.
Boston, MA

Policy debates over the nation's health care financing are hardly new. The matter was addressed comprehensively in the Affordable Care Act (ACA),[1] which leveraged and built on existing market and regulatory structures: employer-based group health insurance, coverage provided by commercial carriers in the individual and group markets, and government programs for low-income individuals, children, and the aged. The ACA peripherally addressed concerns relating to surprise medical bills in the emergency context requiring only that plans and insurers that cover emergency services do so without requiring prior authorization and regardless of whether a provider participates in the plan's network. It was not until after the ACA's enactment that surprise medical billing was first widely recognized as a problem that need the attention of policymakers.

BACKGROUND

The term ''surprise medical bill'' describes the charges that are assessed when an insured individual inadvertently receives medical care from an out-of-network provider. According to the Kaiser Family Foundation,

> This situation could arise in an emergency when the patient has no ability to select the emergency room, treating physicians, or ambulance providers. Surprise medical bills might also arise when a patient receives planned care from an in-network provider (often, a hospital or ambulatory care facility), but other treating providers brought in to participate in the patient's care are not in the same network. These can include anesthesiologists, radiologists, pathologists, surgical assistants, and others. In some cases, entire departments within an in-network facility may be operated by subcontractors who don't participate in the same network. In these non-emergency situations, too, the in-network provider or facility generally arranges for the other treating providers, not the patient.[2]

The debate over surprise medical bills pits health care providers against payors (insurance carriers, employer plans) and uninsured individuals. Principally, though not exclusively, the argument is over the extent to which patients and/or payors are responsible for the payment of unanticipated out-of-network charges. Providers favored an independent dispute resolution (IDR) process; payors and uninsured individuals pushed for a government-defined ''benchmark'' rate.

The fight over surprise billing was *never* about whether and how patients should be protected. There was and is widespread agreement that patients should not be subject to unanticipated medical bills that could cause financial stress or even ruin. Rather, the debate is over how much insurers and self-insured plans are required to pay for these out-of-network charges.

Congress addressed the matter of surprise medical bills in Title I of Division BB of the Consolidated Appropriations Act, 2021[3] (entitled the ''No Surprises Act'') opting for an IDR process that was roundly criticized by both sides:

- Payers were annoyed that they failed in their quest for a benchmark rate – although their con-

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[*] Alden Bianchi is the Practice Group Leader of Mintz P.C.'s Employee Benefits & Executive Compensation Practice.

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[1] 42 U.S.C. §18011, et. seq. (2010).

[2] Karen Pollitz, *Surprise Medical Bills*, Kaiser Family Foundation (Mar. 17, 2016).

[3] Pub. L. No. 116-260 (Dec. 27, 2020) (CAA).

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cerns appear to have been tamped down, at least for the moment, in an interim final rule described below.

- Providers were irked by a provision under which the arbiter under the IDR process can only take certain factors into consideration (e.g., the median in-network rate in the geographic area for the particular medical item or service) and are barred from considering others (e.g., the provider's ''billed charges''). From the provider's perspective, the result looked suspiciously like a ''benchmark'' rate. Also, for reasons explained below, their suspicious may be well-founded.

THE LEAD UP TO THE NO SURPRISES ACT: EXECUTIVE ORDER 13877

In part in an effort to break the logjam of surprise medical billing, the Trump Administration issued Executive Order 13877 of June 24, 2019, *Improving Price and Quality Transparency in American Healthcare To Put Patients First* (the ''Executive Order'').[4] Section 2 of the Executive Order announced that:

> It is the policy of the Federal Government to ensure that patients are engaged with their healthcare decisions and have the information requisite for choosing the healthcare they want and need. The Federal Government aims to eliminate unnecessary barriers to price and quality transparency; to increase the availability of meaningful price and quality information for patients; to enhance patients' control over their own healthcare resources, including through tax-preferred medical accounts; and to protect patients from surprise medical bills.

Medical Billing and Transparency — Provider Rule

Section 3(a) of the Executive Order directed the Secretary of Health and Human Services to propose a regulation,

> [C]onsistent with applicable law, to require hospitals to publicly post standard charge information, including charges and information based on negotiated rates and for common or shoppable items and services, in an easy-to-understand, consumer-friendly, and machine-readable format using consensus-based data standards that will meaningfully inform patients' decision making and allow patients to compare prices across hospitals. The regulation should require the posting of standard charge information for services, supplies, or fees billed by the hospital or provided by employees of the hospital. The regulation should also require hospitals to regularly update the posted information and establish a monitoring mechanism for the Secretary to ensure compliance with the posting requirement, as needed.

In response to this provision of the Executive Order, the Secretaries of Health and Human Services, the Treasury, and Labor issued a final rule entitled, *Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals To Make Standard Charges Public*.[5] Once fully phased in, the final rule required hospitals to publicly disclose, in a machine-readable and consumer-friendly format, five types of charges for their 300 most shoppable services: gross charges, discounted cash prices, payer-specific negotiated charges, de-identified minimum negotiated rates, and de-identified maximum negotiated rates.[6]

The American Hospital Association (AHA) challenged the final rule in the U.S. District Court for the District of Columbia on December 4, 2019, arguing that negotiated rates between various stakeholders are confidential.[7] On cross motions for summary judgment, the district court held for the government, observing that hospitals were trying to limit patients' insight into medical prices by ''attacking transparency measures generally,''[8] which was an insufficient ground upon which to successfully challenge the final rule. The court similarly rejected the AHA's other positions, including its arguments that the rule would drive up prices and create administrative burdens for hospitals. A three-judge panel of the U.S. Court of Appeals of the District of Columbia upheld the decision of the district court.[9]

The Transparency in Coverage Rule

Section 3(b) of the Executive Order included a similar, if less detailed, direction to the Secretaries of Health and Human Services, the Treasury, and Labor to commence rulemaking to require healthcare providers, health insurance issuers, and self-insured group health plans to provide or facilitate access to information about expected out-of-pocket costs for items or services to patients before they receive care. In response, on October 29, 2020, the Department of

[4] 84 Fed. Reg. 30,849 (June 27, 2019).

[5] 84 Fed. Reg. 65,524 (Nov. 27, 2019).

[6] 84 Fed. Reg. 65,524

[7] *The American Hospital Assoc. v. Azar*, 468 F. Supp. 3d 372 (D.D.C. 2020).

[8] *Azar*, 468 F. Supp. 3d 372, 394.

[9] *American Hospital Assoc. v. Azar*, 983 F.3d 528 (D.C. Cir. 2020).

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Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury (the ''Departments'') issued a ''Transparency in Coverage'' (''TiC'') final rule[10] under which:

- Non-grandfathered group health plans and health insurance issuers offering non-grandfathered health insurance coverage in the individual and group markets will be required to make available to participants, beneficiaries and enrollees (or their authorized representative) personalized out-of-pocket cost information, and the underlying negotiated rates, for all covered health care items and services, including prescription drugs, through an internet-based self-service tool and in paper form upon request. An initial list of 500 shoppable services will be required to be available via the internet-based self-service tool for plan years that begin on or after January 1, 2023. The remainder of all items and services will be required for these self-service tools for plan years that begin on or after January 1, 2024.
- Non-grandfathered group health plans or health insurance issuers offering non-grandfathered health insurance coverage in the individual and group markets will be required to make publically available three separate machine-readable files that include detailed pricing information relating to (i) negotiated rates for covered items and services between the plan or issuer and in-network providers, (ii) historical payments to, and billed charges from, out-of-network providers, and (iii) in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level.

The rule also allows issuers to take credit for any resulting ''shared savings'' in their medical loss ratio (MLR) calculations.

Surprise Medical Billing

Section 7 of the Executive Order directed the Secretary of Health and Human Services to take steps ''to address the problem of surprise medical billing.'' Despite the explicit presidential direction in the matter, it was Congress that took the initiative in Title I of Division BB of the CAA entitled ''*The No Surprises Act*.'' This provision of the CAA generally requires group health plans to cover ''surprise'' medical bills for emergency services, including air ambulance services, as well as out-of-network provider bills for services rendered at in-network hospitals and facilities without prior authorization at in-network rates.

THE NO SURPRISES ACT

The No Surprises Act establishes federal standards to resolve surprise bills for the fully insured individual, small group, and large group markets and for self-insured group plans, including grandfathered and transitional relief plans for plan and policy years beginning on and after January 1, 2022. The law's provisions relating to surprise medical bills generally bar surprise billing and limit out-of-network cost sharing in three discreet instances: emergency services rendered by out-of-network providers/facilities, services provided by out-of-network providers at in-network hospitals or facilities, and air ambulance services. A parallel set of rules governs payments by providers. The rules prevent balance billing of patients (or hold patients liable) for any amounts exceeding in-network charges. Lastly, the law establishes an Independent Dispute Resolution (IDR) process to resolve disputes between out-of-network providers and insurers/health plans.

On July 1, 2021, the Departments issued an interim final rule (IFR) that address some, but not all, of the provisions of the Act.[11] This IFR is referred colloquially as ''part 1.'' The IFR established rules for determining the median in-network contracted rate used for both cost sharing and calculating the Qualifying Payment Amount. Among other things, the IFR also further defined certain statutory terms (like ''emergency services,'' ''post-stabilization services,'' and ''nonparticipating providers/health care facilities''); explained how the surprise billing payment process will work; dealt at length with the impact of ERISA preemption; prescribed rules prohibiting nonparticipating providers, facilities and air ambulance services from balance billing participants unless certain notice and consent requirements are satisfied; and expanded on the obligation of plans and providers to provide notices to participants. There are also many items that the IFR did not address, but which the Departments promised to address this year. Most importantly, there include details on the mechanics of the IDR process and the accompanying patient protections.

Covered Plans and Services

The provisions of the No Surprises Act apply broadly to group health plans (including grandfathered plans) and health insurance issuers in the group and individual markets. They are codified in a new Part D of title XXVII of the Public Health Service Act (PHS Act), and in new provisions to part 7 of ERISA, and subchapter B of chapter 100 of the Internal Revenue Code (the ''Code''). The law also grafts similar

[10] 85 Fed. Reg. 72,158 (Nov. 12, 2020)

[11] 86 Fed. Reg. 36,872 (July 13, 2021).

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rules onto the Federal Employees Health Benefits Act (FEHBA),[12] (FEBHA comprehensively governs the health benefits of federal workers and contractors).

Emergency Services

Under §2719A of the PHS Act, as added by the ACA and incorporated into ERISA and the Code, if a non-grandfathered group health plan or health insurance issuer offering non-grandfathered group or individual health insurance coverage provides any benefits with respect to emergency services in an emergency department of a hospital, the plan or issuer must cover emergency services without the individual or the health care provider having to obtain prior authorization (including when the emergency services are provided out-of-network) and without regard to whether the health care provider furnishing the emergency services is an in-network provider with respect to the services. The emergency services must be provided without regard to any other term or condition of the plan or health insurance coverage other than the exclusion or coordination of benefits, an affiliation or waiting period permitted under the Code, ERISA, and the PHS Act, or applicable cost-sharing requirements.

The ACA's rules governing emergency services were the subject of interpretive guidance,[13] under which a plan or issuer satisfies the ACA's out-of-network emergency care cost sharing limitations if it provides benefits for out-of-network emergency services in an amount at least equal to the greatest of the following three amounts (i) the median amount negotiated with in-network providers for the emergency service, (ii) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable (UCR) amount), or (iii) the amount that would be paid under Medicare Part A or Part B for the emergency service. But the ACA's emergency services rule addresses balance billing in the context of the amount that a plan or issuer must pay before a patient becomes responsible for a balance billing amount. Prior to the enactment of the No Surprises Act, these minimum payment standards were the only federal consumer protections to reduce potential amounts of balance billing for individuals enrolled in group health plans and group and individual health insurance coverage. The No Surprises Act amended §2719A of the PHS Act to include a sunset provision effective for plan years beginning on or after January 1, 2022.[14]

The No Surprises Act adds a new layer of consumer protections, under which, if a group health plan or a health insurance issuer covers any in-network emergency items/services, the plan or issuer must cover the same items/services regardless of whether they are provided by a non-participating provider/facility, subject to the requirements for cost sharing, payment amounts, and dispute resolution.[15] Coverage for emergency services must be provided without any prior authorization requirements or with administrative requirements or coverage limits that are more restrictive than those applicable to in-network emergency services.

After emergency services are furnished by an out-of-network provider, the patient is only responsible for paying to the out-of-network provider the portion of the ''Recognized Amount'' for which the participant is responsible based on the cost-sharing requirement that would apply if the service was furnished by an in-network provider. Or put more simply, all emergency services are treated as in-network from the patient's perspective. Cost-sharing requirements still apply. Thus, if a plan imposes cost sharing for emergency services furnished by an in-network provider of, say, 20%, the cost sharing for the same services from an out-of-network service must be no greater than 20%. In addition, if the patient has not met his or her deductible yet, the patient is responsible for paying the entire cost of the out-of-network service before his or her deductible is met. Similarly, if the cost of a particular medical item or service furnished by an out-of-network provider is $1,000, but the participant has a $1,500 deductible, none of which the patient has paid any amounts toward, the patient is responsible for paying $1,000 (not 20% of the $1,000 bill). But once the participant has satisfied the deductible, and at the point at which the plan's coverage and cost sharing applies, the 20% cost sharing would apply.

The ''Recognized Amount'' that the patient is required to pay all or a portion of is defined as being equal to one of the following three amounts:

- if the medical item or service is furnished in a state that has in effect a surprise medical billing law, the amount is determined by that state surprise billing law;
- if the medical item or service is furnished in a state that has no state surprise billing law, the amount is the Qualifying Payment Amount; or
- if the medical item or service is furnished in a state that has an All-Payer Model Agreement, the amount equals an amount approved by the state under that system.[16]

The ''Qualifying Payment Amount'' is defined as the median of contracted rates for a given service in

[12] 5 U.S.C. §8901, et seq.

[13] Reg. §54.9815-2719A(b); 29 C.F.R. §2590.715-2719A(b); 45 C.F.R. §147.138(b).

[14] No Surprises Act, §102(a)(3).

[15] No Surprises Act, §102.

[16] Only two states currently have All-Payer Model Agreements,

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the same geographic region within the same insurance market (i.e., non-group, fully-insured large group, fully-insured small group, or self-insured group) across all of an issuer's health plans as of January 31, 2019, inflated forward by the CPI-U. Special rules apply in instances in which an insurer was not in a particular market or did not cover a particular service in 2019.

Emergency services include coverage for items and services for medical screening to stabilize the covered individual and to transfer them to an in-network facility or home. Medical services include additional services provided by an out-of-network provider or facility as part of an out-patient observation or inpatient or out-patient stay with respect to the emergency services visit if the benefits would be otherwise covered. An out-of-network provider may balance bill the patient for covered services provided after the patient is stabilized, provided (i) the provider or facility determines that the individual can travel using nonmedical transportation or nonemergency medical transportation, (ii) the provider furnishes notice that the additional items/services are out-of-network and the cost and receive an acknowledgement from the patient, and (iii) the individual is in a condition to acknowledge the notice.

The rules barring balance billing of emergency services apply to patients, *not* providers. Providers may still charge extra for out-of-network service, although the new law establishes mechanisms that may put downward pressure on the amounts actually collected, however. The provision requires group health plan to send an initial payment or a notice of denial of payment to the provider or facility within 30 calendar days of the non-participating provider sending the bill. If a bill is disputed, it can be referred to IDR. Notably, nothing in the provision specifies the amount of the ''initial payment'' that the group health plan or issuer must send to the provider. Rather, the amount proffered establishes the plan's or issuer's position for purposes of the independent dispute resolution process.[17]

Non-emergency Services Furnished By Nonparticipating Providers at Participating Facilities

Similar rules apply in the case of non-emergency services furnished by nonparticipating providers at participating facilities. After a medical item or service is furnished by an out-of-network provider at an in-network facility, the patient is only responsible for paying to the out-of-network provider the portion of the Recognized Amount, subject to cost sharing in the manner described above. There is, however, a narrow exception under which balance billing is allowed in certain, non-emergency instances with an individual's advance consent in advance. This might occur, for example, where an individual seeks out the services of a particular out-of-network physician. To qualify providers must furnish a cost estimate and get the individual's consent at least 72 hours before treatment. This also an exception to this exception: it is not available to certain types of providers, e.g., anesthesiologists, radiologists, pathologists, neonatologists, assistant surgeons or laboratories.

Air Ambulance Services Furnished By Nonparticipating Providers of Air Ambulance Services

If a group health plan or a health insurance issuer has a network of participating providers and covers any air ambulance benefits, the plan or issuer must cover services provided by an out-of-network air ambulance carrier, even if the plan or issuer does not have any in-network air ambulance carriers, subject to the requirements for cost sharing, payment amounts, and dispute resolution.

The No Surprises Act requires providers of air ambulance services to submit data to HHS, including data on transportation and medical costs, data on air ambulance bases and aircraft, the number and nature of air ambulance transports, payor data, and data on claims denials. The No Surprises Act also requires plans and issuers to report information about claims data for air ambulance services. The No Surprises Act further requires HHS, along with the Department of Transportation, to produce a comprehensive, publicly available report on air ambulance services that is expected to help shed light on the drivers of the high costs of these services. The Act also requires issuers of individual health insurance coverage or short-term, limited-duration insurance (STLDI) to disclose to enrollees, prior to finalizing enrollment and on documentation confirming the individual's enrollment, direct and indirect agent and broker compensation associated with enrolling individuals in such coverage, and to report similar information to HHS. These disclosures and reporting requirements generally apply to contracts executed after December 27, 2021.

On September 10, 2021, the Departments and the Office of Personnel Management (OPM) issued a notice of proposed rulemaking (NPRM), entitled ''Reporting Requirements Regarding Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement.''[18] This proposed rule would establish new reporting requirements regarding air ambulance services, new disclosure, and reporting requirements

Maryland and Vermont.

[17] Discussed above.

[18] 86 Fed. Reg. 51,730 (Sept. 16, 2021).

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on issuers of individual health insurance coverage and STLDI regarding agent and broker compensation, new procedures for enforcement of PHS Act provisions against providers, facilities, and providers of air ambulance services, and revisions to existing PHS Act enforcement procedures for plans and issuers.

Coordination with State Law

The provisions of the No Surprises Act related to medical billing establish a federal regulatory floor that coordinates with and defers to state law. Nevertheless, because ERISA generally preempts state law, a self-insured plan participant will pay to an out-of-network provider the portion of the Qualifying Payment Amount (i.e., the in-network median rate for the particular medical item or service in a geographic region) for which the participant is responsible based on the cost-sharing requirement that would apply if the medical item or service was furnished by an in-network provider. Sponsors of self-funded plans may, however, voluntarily ''opt in'' to a state surprise billing law, where the state law otherwise allows, in which case, they must follow all of the state's surprise billing protections.

Independent Dispute Resolution

Where a medical provider and a payor (i.e., a group health plan or carrier) disagree on the amount due for a service or procedure, the parties are encouraged to work out acceptable payment terms or submit to ''baseball-style'' arbitration. Insurers and providers have 30 days to negotiate payment of out-of-network bills. If that fails, the claims are submitted to an independent arbitrator, whose decision is final and binding. In the case of uninsured individuals, the Act directs the Department of Health and Human Services to establish a parallel dispute resolution process.

The law establishes the IDR framework. While participants and other covered individuals are protected against balance billing, plans and carriers are not, at least in most instances. Where plans and providers fail to agree, either party may initiate the IDR process within four days of the conclusion of the 30-day open negotiation period. The plan and provider then have three business days to jointly select the IDR entity to oversee the case; should that fail, the HHS Secretary has up to three business days to select one on their behalf. A plan has up to 10 days to submit the amount that it feels it should be required to pay, with any information supporting the plan's suggested payment amount. The provider may thereupon submit its counteroffer, along with any information supporting the provider's suggested payment amount. The arbiter will then decide what the final payment amount should be. The arbiter's decision is 100% binding on both parties, although the parties are free to negotiate out their own payment amount.

While adjudicating a dispute, the arbiter is permitted to take into account the following factors when determining a final payment amount:

- The level of training or experience of the provider;
- Quality and outcome measures adopted by the provider;
- Market-share held by the provider or the self-insured plan in the geographic area;
- Patient acuity and complexity of services provided;
- Teaching status of the provider;
- Efforts (or lack thereof) made by the provider to join the self-insured plan's network and the efforts (or lack thereof) made by the self-insured plan to accept the provider in its network;
- Any contracted rates over the prior four years.

In addition, the arbiter is barred from taking into account the following when determining a final payment amount:

- A provider's usual and customary charges;
- A provider's ''billed charges''; and
- Rates paid by Medicare, Medicaid, CHIP, and TRICARE.

Once the arbiter determines the final payment amount, the loser is required to pay ALL of the costs associated with the arbitration/IDR process.

There is, in addition, a 90-day ''cooling off period,'' under which if a provider submits a claim with respect to a particular medical item or service provided to a particular patient, the provider is prohibited from taking the same plan to arbitration for the same medical item or service provided to other patients who are covered under the plan for at least 90 days. Nevertheless, a claimant is permitted to ''batch'' together out-of-network charges for the same medical item or service covered by the plan, but these charges would generally all have to occur within the same 30-day period (not very likely or practical).

On October 7, 2021, the Departments published a second interim final rule, entitled ''Requirements Related to Surprise Billing; Part II'' (''IFR Part II'').[19] The rule establishes the federal IDR process. Plans and out-of-network providers and facilities may use this IDR process where they fail to reach agreement

[19] 86 Fed. Reg. 55,980 (Oct. 7, 2021).

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on a payment amount during the prescribed 30-day negotiation period. While the IFR Part II generally tracks the statute, there is at least one controversial clarification: In resolving the disputes through the federal IDR process, the arbitrator, which the rule refers to as the ''IDR entity,'' must begin with the presumption that the QPA is the appropriate out-of-network rate for the disputed item or service. The IDR entity must select the offer closest to the QPA unless the IDR entity ''determines that credible information submitted by either party clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate, based on the additional factors set forth in'' the statute.[20] Recall that the QPA is a plan's or issuer's median contracted rate for a particular item or service. Providers claim[21] that, instead of producing non-inflationary market-rate physician payments, the QPA will instead produce reimbursement rate rates that are weighted in favor of the large carriers, particularly in regional markets where completion is less than robust.

Despite the presumption in favor of the QPA, IFR Part II specifies additional circumstances that an IDR entity must take into account in selecting an offer in instances in which a party submits information about the additional circumstance that the IDR entity determines to be *credible*, i.e., the information is worthy of belief and consists of trustworthy information. This information includes practice size, practice specialty or type; information about the plan or issuer's coverage area; information about the QPA; and, if applicable, information showing that the federal IDR process is inapplicable to the dispute. In addition, the certified IDR entity may request additional information relating to the parties' offers and must consider credible information submitted to determine if it demonstrates that the QPA is materially different from the appropriate out-of-network rate (unless the information relates to a factor that the certified IDR entity is prohibited from considering).

CONSEQUENCES

In-network median rates for medical items and services routinely paid or reimbursed by employer-sponsored plans are often hundreds percent of Medicare prices. According to the most currently available Centers for Medicare & Medicaid Services data,[22] Medicare and Medicaid together represent 37% of our national health expenditure, or about $1,413 billion, while private health insurance represents 31 percent, or about $1,195 billion. The difference in reimbursement rates means that employers and employees are subsidizing the nation's health care bill to tune of hundreds of billions of dollars each year. The No Surprises Act does not change this.

Commentators have generally characterized the provision in IFR Part II under which an arbiter must begin with the presumption that the QPA is the appropriate out-of-network rate for the disputed item or service as a win for employer plans. This ''win'' when viewed in the larger context of health care financing is at the margins, and it may even be pyrrhic: The provider community can be expected to push back, since the effect of the presumption is to make *all* services in-network. Providers can also be expected to look for ways to make up for the resulting lost revenue somehow.

The real winners under the No Surprises Act are easy to spot: they are employees and their beneficiaries covered under group health plans, individuals covered under individual health insurance policies, and uninsured and self-pay individuals who now have some solid protections against surprise medical bills.

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[20] Reg. §54.9816–8T(c)(4)(ii)(A).

[21] *See, e.g.,* A. Robeznieks, ''Don't skew surprise-billing regulations in health plans' favor'' (Oct. 1, 2021).

[22] Centers for Medicare & Medicaid Services Fact Sheet, ''National Health Expenditure Data.''

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